

cases of cure following posterior operation, are really brought about by local and general rest—by putting patients in such a position that they cannot, by overexertion of any kind, make a bad matter worse. The retina, having meantime broken loose from its connection with the shrinking vitreous, returns to its normal position, and the treatment, medical or surgical, receives the credit.—*Transactions Section on Ophthalmology, American Medical Association, 1896.*

Cocaine in Glaucoma.—GROENOW (Breslau) has no fear as to harm from the employment of cocaine in eyes presenting a glaucomatous condition (*La Semaine Médicale*, 16 Ann. No. 40). He has never seen it do harm; but, on the contrary, its use has often been attended with good results. It diminishes acute pain, lessens the hyperæmia, and does not raise the tension of the eyeball. By its mydriatic effect it allows of the better examination of the eye.

OBSTETRICS.

UNDER THE CHARGE OF

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The Choice of Version or Forceps in Moderate Pelvic Deformity.—In the *British Medical Journal*, 1896, No. 1870, is published a paper by MILNE MURRAY, in which he advocates the use of forceps in cases of flattened pelvis in which the head presents transversely in the pelvic brim. Murray states that the choice of version in these cases has been based upon the belief that the forceps, applied in the antero-posterior diameter of the head, tends to compress it antero-posteriorly, and to cause a bulging of the transverse or biparietal diameter. This would increase the difficulty of extraction, as the biparietal diameter is already brought into relation with the smallest diameter of the pelvic brim. Murray doubts the truth of this belief, because he has shown by experiment that when the head is grasped over the occiput and forehead that the occipito-frontal diameter may be compressed one and one-half inches without increasing the biparietal. A vertical and not a transverse expansion results. The various segments of the cranium slide under each other in a telescopic manner.

To succeed in delivering the fetal head presenting transversely in the brim of a flattened pelvis the forceps must not only grasp the head in its antero-posterior diameter, but must also make traction downward and backward in the axis of the pelvis. The head naturally passes through the brim, in these cases, by an exaggeration of Nægele's obliquity, by which the posterior parietal eminence pivots against the promontory of the sacrum, while

the anterior moulds itself against the pubes. Murray stated that he had delivered living children where the antero-posterior pelvic diameter was three and one-quarter inches, and even as little as two and three-quarters inches. To secure perfect axis-traction he has attached to his forceps a handle which is movable upon a right-angled traction-bar; by this means he can vary the direction of his traction to suit the abnormalities of the pelvis.

In discussion, FOTHERGILL and CAMERON agreed essentially with Murray. KERR thought that success in such extractions was obtained by rotating the head obliquely into one of the oblique diameters of the pelvic brim. He thought that it is rare to find the two halves of a pelvis of equal size, and that in difficult labor the head will enter the larger portion of the pelvis. He believed that the head rarely passed through the pelvic brim in a strictly transverse position.

(The editor, from his experience, is inclined to indorse the views of Dr. Kerr on this question. While it is no doubt possible to deliver the head in many cases as Dr. Murray indicates, still in many others the head moulds itself into an irregular, oblique position. The suggestion of Dr. Murray that the line of traction should be strongly backward as well as downward is most valuable. In a recent case, in a flat pelvis where the first child had been lost by pressure, and where others had failed with forceps, success was achieved by putting the patient in Walcher's position and by making traction in exaggerated downward and backward direction. A living child was delivered with Simpson's forceps, axis-traction being effected by the use of tapes.)

Successful Cæsarean Section upon a Rhachitic Patient, Performed at Her Home.—In *Le Progrès Médical*, 1896, No. 46, BÉCHET reports the case of a woman, aged thirty-eight years, having a highly contracted rhachitic pelvis, who had been in labor at intervals during three days when he was called to attend her. The head of the child was evidently large and could not descend into the pelvis. The mother was in fair condition, without infection, and her excretion fairly well performed. Symphysiotomy was declined because of the high degree of pelvic contraction, and the Cæsarean section undertaken. This was performed in the usual manner, the placenta being found beneath the line of incision and some hemorrhage occurring when the uterus was opened. This was controlled by injections of ergotin and the application of gauze-pads wrung out of hot, sterile water. The muscle of the uterus and its peritoneal covering were sutured separately and with great care, and the abdomen closed. The patient made an uninterrupted recovery. This case illustrates the fact that the Cæsarean section may be successfully performed without the advantages afforded by a hospital.

Studies in the Blood of the Newborn.—In the *Wiener klinische Wochenschrift*, 1896, Nos. 41 and 43, are published two very interesting papers, one upon "Melæna" and the other upon the "Condition of the Red Blood-cells in Cases of Icterus Neonatorum." The first paper is by SWOBODA, one of the physicians to the Vienna Foundling Asylum. In this paper he narrates a number of cases of infants dying with passive hemorrhages from the nose,

mouth, and intestine. In a number of these post-mortem examination revealed the lesions of congenital syphilis. In others septic infection occasioned by the gonococcus was the primary cause of the bleeding. In others a meningitis had developed without lesions of syphilis. No cause other than a mechanical one from pressure upon the head, or excessive coughing or straining, could be found for the condition. He also reports several cases of bleeding from the nose in infants, in which bacteriological examination showed the presence of the bacillus of diphtheria as a cause. His interesting paper serves to illustrate the fact that melæna is a symptom only, whose cause must always be sought before the pathology or treatment of a given case becomes evident.

KNOEFFELMACHER has studied the icterus of the newborn, and the relation which the condition of the red blood-cells bears to this phenomenon. His conclusions are essentially as follows: in the first weeks of life the number of red blood-cells is not influenced by a condition of icterus. Variations in the number of red corpuscles depend upon changes in the quantity and quality of the blood-plasma. The resisting power of the red corpuscles at birth seems to be fully that possessed by these cells in the adult, and does not seem to be lessened by icterus, however intense. The microscopic examination of the blood of the newborn in these cases shows, during the first days of life, no sign of erythrocytes, but, on the contrary, gives only indications of a vigorous building-up of red blood-cells. The conclusion of these studies is in general that the condition of icterus in the newborn does not influence essentially the red blood-cells.

Purpura Hemorrhagica in a Newborn Child with Congenital Syphilis.—In the *Revue Mensuelle des Maladies de l'Enfance*, November, 1896, JOLLY reports the case of an infant, nineteen days old, who died of purpura hemorrhagica, in whom autopsy showed intestinal ulceration and lesions characteristic of congenital syphilis. Other possible causes of these phenomena were carefully excluded in making a diagnosis.

The Use of the Phonendoscope in Obstetric Diagnosis.—In the *Prager medicinische Wochenschrift*, 1896, No. 46, KNAFF reports his observations in the use of this instrument. He agrees with PRIBRAM in the value of the instrument, and has found it especially useful in diagnosing twin pregnancy, and also in detecting coiling of the cord about the fetus. When a murmur can be located over the fetus a little slower than the fetal pulse, but more rapid than the maternal aorta, and differentiated from the placental bruit, a diagnosis of coiling of the cord about the fetus may be considered as reasonably certain. In twin-pregnancy the two heart-sounds may be more readily diagnosed by this means. The location of the placenta can also be ascertained by the use of the phonendoscope.

Symphysiotomy.—In the *Edinburgh Medical Journal*, December, 1896, DONALD reports three symphysiotomies. The first was upon a multipara who had borne five children, four of them stillborn. A general contraction of the pelvis is said to have been present, with a true conjugate of three and one-quarter inches. The patient was admitted to the hospital in the second

stage of labor, and no progress was made for three hours, although the pains were strong. The joint was opened by an incision above the pubes, the joint-surfaces separating nearly an inch. The head was adjusted to the brim and easily delivered by axis-traction forceps. The extent of separation during delivery was about two and one-half inches. The child was of average size, and a healthy female. Buried silk sutures were employed in the periosteum and the skin was closed with silkworm-gut. The pelvis was strapped, a firm bandage applied, and sandbags placed on each side of the pelvis. The patient left the hospital at the end of six weeks in good condition.

Case II. was in her second labor, the first having been terminated by the birth of a stillborn child with forceps. The pelvis was of the same type as the preceding. She was admitted to the hospital, having been in labor for twenty-four hours. The cervix was widely dilated, the head not engaged, the heart-sounds distinct. After symphysiotomy the delivery was difficult, the bones separating fully two and three-quarters inches. A living female child of average size was extracted. The patient's convalescence was somewhat hindered by swelling and suppuration of the labia. The patient was up in four weeks, and the final result was good.

Case III. was a multipara who had lost six children through embryotomy, premature labor, and tedious spontaneous labor. The true conjugate was three and one-quarter inches. Patient admitted to hospital in labor, the membranes having ruptured sixty hours before admission. As dilatation was but partly complete, de Ribes's bag was employed. The pubes separated about two inches during delivery. A puny male child was born, which required resuscitation. Patient got up in nineteen days, but was kept in hospital on account of the illness of the child. The infant developed congenital syphilis and died three months after birth.

In the *Boston Medical and Surgical Journal*, December 17, 1896, SWIFT reports the first symphysiotomy performed in Boston or vicinity. The patient was in her second labor, having been delivered of her first child by craniotomy. The patient had been in labor about twenty-four hours; the os was fully dilated and the membranes ruptured. The pelvis was symmetrically contracted, the external conjugate being seven and one-half inches. The true conjugate was estimated at about three inches. The patient was taken to a hospital and symphysiotomy performed by supra-pubic incision. The patient was delivered by forceps, the pubic bones separating about one and one-half inches. The child was resuscitated without difficulty. The pelvis was brought together by firm pressure, and a heavy silk suture passed through the bones, a wire suture having broken. The pelvis was fixed by a broad band of adhesive plaster. A self-retaining catheter was placed in the bladder. The incision healed on the fifth day, and abscess formed in the line of incision. This was readily emptied, and occasioned but slight disturbance. The patient nursed her child. In the discussion which followed the report of this case the balance of opinion was in favor of Cæsarean section as being the less dangerous and more feasible operation. It was recognized that a field for symphysiotomy exists in well-chosen cases.

In the *Medical News*, January 16, 1897, the writer reported a symphysiotomy, performed in January, 1896, upon a patient whose first child had

been delivered with difficulty by forceps. This child survived. Spontaneous labor in the second instance had failed, and the physician in attendance had not succeeded in delivering with forceps. The head was but partially engaged; the heart-sounds were very rapid. The pelvis was symmetrical in contour, but contracted in all its diameters from one-half to two cm. The ground for symphysiotomy was disproportion between the pelvis and the fœtus, due not only to the pelvic contraction, but to the increase in the size which the fœtus displays in repeated pregnancy. The heart-sounds of the fœtus were very rapid, but distinct. Symphysiotomy was performed by suprapubic incision, the joint being readily opened with a bistoury. The occiput rotated posteriorly, and the child was delivered with axis-traction forceps. It was a male, weighing eight pounds, its measurements in several of the diameters of its head being from one-half to one cm. above the average. A very perceptible odor was noticed when the child was delivered; it survived eighteen hours, perishing from inspiration-pneumonia. The mother developed sapræmia, but made a good recovery. A slight discharge of sanious fluid issued from the incision for several days. She made a complete recovery and left the hospital seven weeks after admission. Subsequent measurement of her pelvis showed an increase in its diameters of one-half cm. One year after operation she was in excellent health, never having experienced the slightest inconvenience from the condition of the pelvis. Sound union in the pubes followed the operation.

GYNECOLOGY.

UNDER THE CHARGE OF

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Etiology and Treatment of Cancer of the Uterus.—BÆCKER (*Archiv für Gynäkologie*, Band liii. Heft 1), from an analysis of 705 cases of cancer of the uterus, arrives at the following conclusions with reference to the etiology of the disease:

1. The true origin of malignant disease of the uterus is as yet unknown, nor can it be referred to a specific micro-organism. 2. The indirect cause is endometritis, generally of puerperal origin, which furnishes a suitable nidus for its development. This is shown by the fact that cancer is common in women who have borne children, while it is comparatively rare in single and in sterile women, as well as in those who have had gonorrhœa. Moreover, in nearly every case of cancer there is a chronic catarrh of the endometrium. Endometritis is the primary condition, malignant degeneration being secondary. Hence the practical importance of treating endometritis actively from the outset as a prophylactic measure.

In the treatment of carcinoma of the cervix total extirpation is always